

## **HOSPITAL AND RESIDENTIAL APPLICATION PROCESS FOR NEW OWNER OF A CURRENTLY LICENSED FACILITY**

According to RSA 151:2 (the Residential Care and Health Facilities Law) a facility or agency may not provide any residential or health care services until a valid license is obtained.

Plans must be submitted to Health Facilities Administration for approval prior to commencing work on construction or structural modifications.

1. Obtain application and local approval form.
2. Obtain determination as to whether or not a Certificate of Need is required:

Health Services Planning and Review  
6 Hazen Drive  
Concord, New Hampshire 03301 (603) 271-4606

The following facilities do not have to obtain this determination:

Assisted Living	Residential Care Home
Supported Residential Care	Residential Treatment and Rehabilitation Facility
Acute Psychiatric Rehab. Neuro -RTRF	Hospice House
Laboratory Services	Collecting Station
Home Health Care	Hospice
Birthing Center	End stage Renal Disease Dialysis Center
Community Residence	ICF/DD
Educational Health Center	Outpatient Clinic
Homemaker	Adult Day Care
Case Management	
Health Promotion, Disease Prevention and Screening Clinic	

UNLESS-you are affiliated with or have an ownership/relationship with any of the following:

Ambulatory Surgical Center  
General Hospital  
Nursing Facility  
Hospice -Supported Residential Care Facility  
Special Hospital -Substance Abuse  
Special Hospital -Psychiatric  
Special Hospital -Rehabilitation  
Freestanding Hospital Emergency Facility

3. Complete all sections of the application.
4. Have local health, building, zoning and fire officers sign approval form. (Zoning officer approval is not necessary for Community Residences.) Date of signatures no more than 30 days prior to submission of application.
5. Determine application fee.
6. Submit #2,3,4 and 5 to Health Facilities Administration, 129 Pleasant Street, Concord NH 03301.

7. Submit qualification, including education, experience and copies of applicable licenses with the application for:
  - a. Administrator.
  - b. Medical Director (if applicable).
8. For new owner of a currently licensed facility, a statement from the holder of the current license acknowledging the application must be attached.
9. Additional Requirements:

If applying for a 4 or more bed Community Residence, please submit both an application for licensure and an application for certification.

If applying for a Home Health Care Provider, Case Management, Equipment Management Organization, Homemaker or Home Health Hospice license, submit:

  - a. Copy of the authority to do business in New Hampshire from the Secretary of State.
  - b. Article of Incorporation or Partnership.
  - c. If applying for a Branch office (see He-P 801.08(h)), submit the information required by He- P 801.02(d)(5).
10. Within 60 days of receipt of the application you will be notified if your application is complete.
  - a. If the application is not complete, you will be informed of what is in error.
  - b. The incomplete application will be returned. When you have corrected the errors or omissions, resubmit the entire application package.
11. Once Health Facilities Administration has received the complete application package, Health Facilities will determine if the facility is in "good standing" and if any of the services to be provided have changed.
12. If the facility is in good standing and there is no change in the service to be provided, you will be contacted to establish a date of sale.
  - a. Once documentation of the sale is received a license and certificate will be issued. b. The license will be for the remainder of the licensure year for the previous owner.
13. If the facility is not in good standing, inspections will occur to determine compliance with RSA 151 He-P 801 and the appropriate regulations.
  - a. If you were in full compliance with all inspection requirements, a license will be issued.
  - b. If any deficiencies were identified, your licensing request will be denied.
14. Within 120 days of receipt of an acceptable application, a decision regarding issuance or denial of your license will be made.
15. If your licensure request is denied, you will have the right to appeal the decision.
16. If you are found to be providing health care services without a license as required by RSA 141:2, a Cease and Desist order will be issued. Legal action including assessing fines may be taken.

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF PROGRAM SUPPORT  
HEALTH FACILITIES ADMINISTRATION  
129 Pleasant Street, Concord, NH 03301  
TDD Access: Relay NH 1-800-735-2964  
Agency Phone: 603-271-3021

**APPLICATION FOR RESIDENTIAL OR HEALTH CARE LICENSE**

LICENSE #: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION.** IF A SECTION DOES NOT APPLY TO YOUR FACILITY MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE COMPLETED FORM TO THE ADDRESS ABOVE.

Check all applicable items:

License renewal:	<input type="checkbox"/>	New administrator:	<input type="checkbox"/>	*New facility:	<input type="checkbox"/>
**New facility name:	<input type="checkbox"/>	*New owner:	<input type="checkbox"/>	*Change in # of beds:	<input type="checkbox"/>
*Change in classification:	<input type="checkbox"/>	*Change in address:	<input type="checkbox"/>	Other (please explain):	<input type="checkbox"/>

\* Requires processing as a new application.

\*\* May require processing as a new application.

LICENSEE: \_\_\_\_\_ TELEPHONE #: (\_\_\_\_) \_\_\_\_\_

NAME OF FACILITY: \_\_\_\_\_ TELEPHONE #: (\_\_\_\_) \_\_\_\_\_

FAX #: (\_\_\_\_) \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADMINISTRATOR: \_\_\_\_\_

MEDICAL DIRECTOR (if applicable): \_\_\_\_\_

LABORATORY DIRECTOR (if applicable): \_\_\_\_\_

DAYS AND HOURS OF OPERATION: \_\_\_\_\_

**IF APPLICABLE:**

NUMBER OF PATIENTS SEEN PER DAY: \_\_\_\_\_

NUMBER OF ESRD STATIONS: Presently licensed \_\_\_\_\_ To be licensed \_\_\_\_\_

NUMBER OF BEDS: PRESENTLY LICENSED: \_\_\_\_\_ TOTAL # TO BE LICENSED: \_\_\_\_\_

ADDRESS, CITY AND STATE OF ANY BRANCH OFFICE (per He-P 801.08(h)) if applicable:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OWNERSHIP**

a.	Type of ownership:	Association:	<input type="checkbox"/>	Partnership:	<input type="checkbox"/>
		Corporation:	<input type="checkbox"/>	Other (explain):	<input type="checkbox"/>
		Individual:	<input type="checkbox"/>		

- b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.
- c. If the licensee is organized as an association or corporation, list the name of the corporation or association and the name, address and title of each officer.
- d. If the licensee is a partnership, list the name(s) and address(es) of all the partners.

<b>FEES:</b>	Facilities with beds	\$2.50 per bed per year
	Facilities without inpatient beds	\$50.00 per year
	Laboratories	\$65.00 per category of testing
	Home Health Care Provider	\$20.00 per year

A check or money order (payable to: **STATE OF NEW HAMPSHIRE, TREASURER**), must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 are not required to pay the license fee.

**APPLICATION FOR LICENSE RENEWAL SHALL:**

- 1. Be submitted at least 120 days prior to expiration of the current license.
- 2. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator and medical director (if applicable).
- 3. Include information relative to whether the facility has been granted any exemptions to the rules by the director of the Department of Health and Human Services and/or the State Fire Marshal.
- 4. Community Residence must submit the information required by RSA 151:4 III (a)(4).

**FACILITY SERVICE DESCRIPTION:**

The following information will be used to determine which licensure category your facility shall be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

\*II. Describe the facility's health care you wish to provide to residents.

\*III. Identify who will provide the health care listed in II.

\* To be completed if applying for beds.

**SIGNATURES:**

This application must be signed by:

1. the owner if a private facility;
2. 2 officers if a corporation;
3. 2 authorized individuals if an association or partnership;
4. the head of the government department if a government unit.

I swear or affirm that the information provided is accurate to the best of my knowledge and belief. The administrator and licensee have never pleaded guilty or been found guilty of abuse, neglect or exploitation by the Division of Elderly and Adult Services, Division of Children and Youth Services or Long Term Care Ombudsman Program, or assault, fraud or a felony against a person in this or any other state. I believe that my facility is in full compliance with RSA 151 and the rules promulgated thereunder. I understand that providing false information shall be grounds for denial, suspension or revocation of a license.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

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CHECK NUMBER: \_\_\_\_\_

AMOUNT: \_\_\_\_\_

APPLICATION COMPLETE: \_\_\_\_\_

NOT COMPLETE: \_\_\_\_\_

(Describe in comments)

CERTIFICATE OF NEED:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
LOCAL APPROVAL:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
LSC INSPECTION:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
LSC PLAN OF CORRECTION:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
LICENSURE INSPECTION:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
PLAN OF CORRECTION:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>
DMH/DS RISK:	Required	<input type="checkbox"/>	Not Required	<input type="checkbox"/>	Received	<input type="checkbox"/>

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

<input type="checkbox"/> 02 General Hospital	<input type="checkbox"/> 17 Collecting Station
<input type="checkbox"/> 03 Nursing Facility	<input type="checkbox"/> 18 Adult Day Care Provider
<input type="checkbox"/> 04 Residential Care Home Fac	<input type="checkbox"/> 19 Case Management Services
<input type="checkbox"/> 05 Supported Residential Care Fac	<input type="checkbox"/> 21 Equipment Management
<input type="checkbox"/> 06 Outpatient Clinic	<input type="checkbox"/> 22 Homemaker Provider
<input type="checkbox"/> 07 Residential Treatment Rehab Fac	<input type="checkbox"/> 23 Hospice Care Provider
<input type="checkbox"/> 08 Laboratory	<input type="checkbox"/> 24 Hospice - SRCF
<input type="checkbox"/> 09 Home Health Care Provider	<input type="checkbox"/> 25 Special Hospital - Substance Abuse
<input type="checkbox"/> 10 Birthing Center	<input type="checkbox"/> 26 Special Hospital - Psychiatric
<input type="checkbox"/> 11 End Stage Renal Dialysis Ctr	<input type="checkbox"/> 27 Special Hospital - Rehabilitation
<input type="checkbox"/> 12 Ambulatory Surgical Facility	<input type="checkbox"/> 28 Freestanding Hosp Emergency Fac
<input type="checkbox"/> 14 Community Residence	<input type="checkbox"/> 29 Hlth Promo, Disease Prev & Screen
<input type="checkbox"/> 15 ICF/DD	<input type="checkbox"/> 30 Acute Psych Rehabilitation Facility
<input type="checkbox"/> 16 Educational Health Center	<input type="checkbox"/> 31 Neurobehavioral RTRF

REVIEWED BY: \_\_\_\_\_  
(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES \_\_\_\_\_ NO \_\_\_\_\_

LICENSE CERTIFICATE DATES: FROM \_\_\_\_\_ TO \_\_\_\_\_

NUMBER OF PATIENTS/STATIONS/BEDS \_\_\_\_\_

NOTES:

COMMENTS ON CERTIFICATE:

**STATE OF NEW HAMPSHIRE**  
**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**OFFICE OF PROGRAM SUPPORT**  
**HEALTH FACILITIES ADMINISTRATION**  
129 Pleasant Street, Concord, New Hampshire 03301-3857  
TDD Access: Relay NH 1-800-735-2964  
Agency Phone Number: 603-271-3021

The facility listed below is requesting to be licensed by the Department of Health and Human Services. Please complete and sign each section. If local approval is not required, please indicate this on the form.

FACILITY NAME: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
OWNER'S NAME: \_\_\_\_\_  
ADMINISTRATORS NAME: \_\_\_\_\_  
FACILITY TELEPHONE NUMBER: \_\_\_\_\_  
PROPOSED TYPE OF FACILITY: \_\_\_\_\_

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**HEALTH OFFICER**

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE  
CITY/TOWN OF \_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_  
**DOES NOT** REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY

NUMBER OF BEDS: \_\_\_\_\_ NUMBER OF ESRD STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF HEALTH OFFICIAL)

PRINT: \_\_\_\_\_  
(NAME AND TITLE OF HEALTH OFFICIAL)

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**BUILDING REGULATIONS**

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE BUILDING REGULATIONS FOR THE CITY/TOWN OF  
\_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_  
**DOES NOT** HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS: \_\_\_\_\_ NUMBER OF ESRD STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF BUILDING OFFICIAL)

PRINT: \_\_\_\_\_  
(NAME AND TITLE OF BUILDING OFFICIAL)

## ZONING REGULATIONS

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF \_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_  
**DOES NOT** HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS: \_\_\_\_\_ NUMBER OF ESRD STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF ZONING OFFICIAL)

PRINT: \_\_\_\_\_  
(NAME AND TITLE OF ZONING OFFICIAL)



## FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2000 EDITION)  
CHAPTER \_\_\_\_.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE FIRE REGULATIONS FOR THIS CITY/TOWN.

I HEREBY CERTIFY THAT THE CITY/TOWN OF \_\_\_\_\_  
**DOES NOT** HAVE LOCAL FIRE REGULATIONS.

NUMBER OF BEDS: \_\_\_\_\_ NUMBER OF ESRD STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(FIRE CHIEF OR DESIGNEE)

PRINT: \_\_\_\_\_  
(FIRE CHIEF OR DESIGNEE)



**COMMENTS:**